

between the facility's assessment of a resident and the assessment of that same resident by the audit staff of Licensing and Protection shall be resolved with the Division of Licensing and Protection and shall not involve the Division of Rate Setting. As the final rates are prospective and adjusted on a quarterly basis to reflect the most current data, the Division of Rate Setting will not make retroactive rate adjustments as a result of audits or successfully appealed individual case-mix scores.

1.10 Computation of and Enlargement of Time; Filing and Service of Documents

(a) In computing any period of time prescribed or allowed by these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a state or federal legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a state or federal legal holiday.

(b) For the purposes of any provision of these rules in which time is computed from the receipt of a notice or other document issued by the Division or other relevant administrative officer, the addressee of the notice shall be rebuttably presumed to have received the notice or other document three days after the date on the document.

(c) When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged. This subsection shall not apply to the time limits for appeals to the Vermont Supreme Court or Superior Court from Final Orders of the Division or Final Determinations of the Secretary, which are governed by the Vermont Rules of Appellate Procedure and the Vermont Rules of Civil Procedure respectively.

(d) Filing shall be deemed to have occurred when a document is received and date-stamped as received at the office of the Division or in

the case of a document directed to be filed under this rule other than at the office of the Division, when it is received and stamped as received at the appropriate office. Filings with the Division may be made by telefacsimile (FAX), but the sender bears the risk of a communications failure from any cause. Filings shall be made by electronic data transfer at such time as appropriate software and filing procedures are prescribed by the Division pursuant to subsection 1.8(d).

(e) Service of any document required to be served by this rule shall be made by delivering a copy of the document to the person or entity required to be served or to his or her representative or by sending a copy by prepaid first class mail to the official service address. Service by mail is complete upon mailing.

1.11 Representation in All Matters before the Division

(a) A facility may be represented in any matter under this rule by the owner (in the case of a corporation, partnership, trust, or other entity created by law, through a duly authorized agent), the nursing facility administrator, or by a licensed attorney or an independent public accountant.

(b) The provider shall file written notification of the name and address of its representative for each matter before the Division. Thereafter, on that matter, all correspondence from the Division will be addressed to that representative. The representative of a provider failing to so file shall not be entitled to notice or service of any document in connection with such matter, whether required to be made by the Division or any other person, but instead service shall be made directly on the provider.

1.12 Severability

If any part of these rules or their application is held invalid, the invalidity does not affect other provisions or applications which can be given effect without the invalid provision or application, and to this end the provisions of these rules are severable.

1.13 Effective Date

These rules are effective from January 29, 1992, (as amended June 18, 1993, July 1, 1994, January 4, 1995, January 1, 1996, January 1, 1997, and July 1, 1998).

2 ACCOUNTING REQUIREMENTS

2.1 Accounting Principles

(a) All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules authorize specific variations in such principles.

(b) The provider shall establish and maintain a financial management system which provides for adequate internal control assuring the accuracy of financial data, safeguarding of assets and operational efficiency.

(c) The provider shall report on an accrual basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the basis of an analysis of the available documentation. In such a case, the provider's accounting process shall provide sufficient information to compile data to satisfy the accrued expenditure reporting requirements and to demonstrate the link between the accrual data reports and the non-accrual fiscal accounts. The provider shall retain all such documentation for audit purposes.

2.2 Procurement Standards

(a) Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors. Providers should participate in group purchasing plans when feasible.

(b) If a provider pays more than a competitive bid for a good or service, any amount over the lower bid which cannot be demonstrated to be a reasonable and necessary expenditure that

satisfies the prudent buyer principle is a non-allowable cost.

2.3 Cost Allocation Plans and Changes in Accounting Principles

With respect to the allocation of costs to the nursing facility and within the nursing facility, the following rules shall apply:

(a) New facilities shall submit to the Division a proposed cost allocation plan within six months of the facility's opening.

(b) Providers that have costs allocated from related entities included in their cost reports shall include, as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements, which must also be submitted with the Medicaid cost report. In the case of a home office or related management company, this would include a completed Home Office Cost Statement. The provider shall submit this reconciliation with the Medicaid cost report.

(c) No change in accounting principles or methods or basis of cost allocation may be made without prior written approval of the Division.

(d) Any application for a change in accounting principle or a change in the method or basis of cost allocation, which has an effect on the amount of allowable costs or the computation of the per diem rate of payment, shall be made within the first 90 days of the reporting year. The application shall specify:

(1) the nature of the change;

(2) the reason for the change;

(3) the effect of the change on the per diem rate of payment; and

(4) the likely effect of the change on future rates of payment.

(e) The Division shall review each application and within 60 days of the receipt of the application approve, deny, or propose modification

of the requested change. If no action is taken within the specified period, the application will be deemed to have been approved.

(f) Each provider shall notify the Division of changes in statistical allocations or record keeping required by the Medicare Intermediary.

(g) Preferred statistical methods of allocation are as follows:

- (1) Nursing salaries and supplies - direct cost,
- (2) Plant operations - square footage,
- (3) Utilities - square footage,
- (4) Laundry - pounds of laundry,
- (5) Dietary -resident days,
- (6) Administrative and General - accumulated costs,
- (7) Property and Related: Depreciation of Equipment - specific identification,
- (8) Property and Related: All other property costs - square footage,
- (9) Fringe Benefits - direct allocation/gross salaries.

(h) Food costs included in allocated dietary costs are calculated by dividing the facility's allocated dietary costs by total organization dietary costs and multiplying by the total organization food costs.

(i) Utility costs included in allocated plant operation and maintenance costs are calculated by dividing the facility's plant operation and maintenance costs by total organization plant operation and maintenance cost and multiplying by the total organization utility costs.

(j) All administrative and general costs, including home office and management company costs, allocated to a facility shall be included in the Indirect Cost category.

(k) The capital component of goods or services purchased or allocated from a related or unrelated party, such as plant operation and maintenance, utilities, dietary, laundry, house-keeping, and all others, whether or not acquired from a related party, shall be considered as costs for that particular good or service and not classified as Property and Related costs of the nursing facility.

(l) Costs allocated to the nursing facility shall be reasonable, as determined by the Division pursuant to these rules.

2.4 Substance Over Form

The cost effect of transactions that have the effect of circumventing the intention of these rules may be adjusted by the Division on the principle that the substance of the transaction shall prevail over the form.

2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the uniform financial and statistical report (cost report), and must, upon request, make these records available to the Division of Rate Setting, or the U. S. Department of Health and Human Services, and the authorized representatives of both agencies.

(b) Complete documentation means clear and compelling evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service schedule and amounts of income received by service, or any other record which is necessary to provide the Director with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any

reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

(c) The provider shall maintain all such records for at least six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later. The Division shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting Summaries of Findings for six years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

(d) Pursuant to 3 V.S.A. §317(b)(6), financial records filed with the Division are not public records (with the exception of those required to be made public by state or federal law, including 42 U.S.C. §1396r(g)(5)(A)(ii)). Such documents may be released with the agreement of the affected provider and/or pursuant to an order of a court of competent jurisdiction. The Division shall from time to time issue a notice of practices and procedures pursuant to Subsection 1.8(d) describing those records that are available to the public.

3 FINANCIAL REPORTING

3.1 Master File

Providers shall submit the following documents for the purpose of establishing a Master file for each facility in the Vermont Medicaid program:

- (a) Copies of the articles of incorporation and bylaws,
- (b) Chart of accounts and procedures manual, including procurement standards established pursuant to Subsection 2.2(a),
- (c) Plant layout,
- (d) Terms of capital stock and bond issues,

(e) Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing and bonus agreements

(f) Schedules for amortization of long-term debt and depreciation of plant assets,

(g) Summary of accounting principles, cost allocation plans and step-down statistics used by the provider,

(h) Appraisals,

(i) and such other documents or information as the Director may require.

3.2 Uniform Cost Reports

(a) Each long-term care facility participating in the Vermont Medicaid program shall annually submit a uniform financial and statistical report (cost report) on forms prescribed by the Division. The inclusive dates of the reporting year shall be the 12 month period of each provider's fiscal year, unless advance authorization to submit a report for a greater or lesser period has been granted by the Division.

(1) The Division may require providers to file special cost reports for periods other than a facility's fiscal year.

(2) The Division may require providers to file budget cost reports. Such cost reports may be used *inter alia* as the basis for new facilities' rates or for rate adjustments.

(b) The cost report must include the certification page signed by the owner, or its representative, if authorized in writing by the owner.

(c) The original and one copy of the cost report must be submitted to the Division. All documents must bear original signatures.

(d) The following supporting documentation is required to be submitted with the cost report:

(1) Audited financial statements (except that at the discretion of the Director, this re-

quirement may be waived for not-for-profit facilities),

(2) Most recently filed Medicare Cost Report (if a participant in the Medicare Program),

(3) Reconciliation of the audited financial statements to the cost report.

(e) A provider must also submit, upon request during the desk review or audit process, such data, statistics, schedules or other information which the Division requires in order to carry out its function.

(f) Providers shall follow the cost report instructions prescribed by the Director in completing the cost report. The chart of accounts prescribed by the Director, shall be used as a guideline providing the titles, and description for type of transactions recorded in each asset, liability, equity, income, and expense account.

3.3 Adequacy and Timeliness of Filing

(a) An acceptable cost report filing shall be made on or before the last day of the fifth month following the close of the period covered by the report.

(b) The Division may reject any filing which does not comply with these regulations and/or the cost reporting instructions. In such case, the report shall be deemed not filed, until refiled and in compliance.

(c) Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:

(1) All Requests for Extension of Time to File Cost Report must be in writing, on a form prescribed by the Director, and must be received by the Division of Rate Setting 15 days prior to the due date. The provider must clearly explain the reason for the request and specify the date on which the Division will receive the report.

(2) Notwithstanding any previous practice, the Division will not grant automatic

extensions. Such extensions will be granted for good cause only, at the Director's sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial reason, one that affords a legal excuse for the delay or an intervening action beyond the provider's control. The following are *not* considered "good cause": ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

(d) Notwithstanding any other provision of these rules, any provider that fails to make an acceptable cost report filing within the time prescribed in subsection 3.3(a) or within an extension of time approved by the Division, shall receive no increase to its Medicaid rate until such time as an acceptable cost report is filed.

3.4 Review of Cost Reports by Division

(a) Uniform Desk Review

(1) The Division shall perform a uniform desk review on each cost report submitted.

(2) The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review for the purpose of either settling the cost report without an on-site audit or determining the extent to which an on-site audit verification is required.

(3) Uniform desk reviews shall be completed within an average of 180 days after receipt of an acceptable cost report filing, except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider.

(4) Unless the Division schedules an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

(b) On-site Audit

(1) The Division will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems in accordance with the relevant provisions of the *Medicare Intermediary Manual - Audits-Reimbursement Program Administration*, HCFA Publication 13-2 (HCFA-13).

(2) The Division will base its selection of a facility for an on-site audit on factors such as length of time since last audit, changes in facility ownership, management, or organizational structure, evidence or official complaints of financial irregularities questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

(3) The audit scope will be limited so as to avoid duplication of work performed by an independent public accountant, provided such work is adequate to meet the Division's audit requirements.

(4) Upon completion of an audit, the Division shall review its draft findings and adjustments with the provider and issue a written summary report of such findings.

(c) The procedure for issuing and reviewing Summaries of Findings is set out in Subsections 15.1, 15.2 and 15.3.

3.5 Settlement of Cost Reports

(a) A cost report is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the Division has issued a final order pursuant to Subsection 15.3 of these rules.

(b) Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division's decision to reopen will be based on new and material evidence submitted by the provider, evidence of a clear and obvious material error, or a determination by the Secretary or a court of competent jurisdiction that the determination is

inconsistent with applicable law, regulations and rulings, or general instructions.

(c) Reopening means an affirmative action taken by the Division to re-examine the correctness of a determination or decision otherwise final. Such action may be taken:

(1) On the initiative of appropriate authority within the applicable time period set out in paragraph (f), or

(2) In response to a written request of the provider or other relevant entity, filed with the Division within the applicable time period set out in subsection (f), and

(3) When the reopening has a material effect (more than one percent) on the provider's Medicaid rate payments.

(d) A correction is a revision (adjustment) in the Division's determination or Secretary's decision, otherwise final, which is made after a proper re-opening.

(e) A correction may be made by the Division, or the provider may be required to file an amended cost report. If the cost report is reopened by an order of the Secretary or a court of competent jurisdiction, the correction shall be made by the Division.

(f) A determination or decision may be reopened within three years from the date of the notice containing the Division's determination, or the date of a decision by the Secretary or a court.

(g) The Division may also require or allow an amended cost report to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, the provider is bound by its elections. The Division shall not accept an amended cost report to avail the provider of an option it did not originally elect.

4 DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

4.1 Provider Reimbursement Manual and GAAP

In determining the allowability or reasonableness of costs or treatment of any reimbursement issue, not addressed in these rules, the Division shall apply the appropriate provisions of the Medicare Provider Reimbursement Manual (HCFA-15, formerly known as HIM-15). If neither these regulations nor HCFA-15 specifically addresses a particular issue, the determination of allowability will be made in accordance with Generally Accepted Accounting Principles GAAP. The Division reserves the right, consistent with applicable law, to determine the allowability and reasonableness of costs in any case not specifically covered in the sources referenced in this subsection.

4.2 General Cost Principles

For rate setting purposes, a cost must satisfy criteria, including but not limited to the following:

- (a) The cost must be ordinary, reasonable, necessary, related to the care of residents, and actually incurred.
- (b) The cost adheres to the prudent buyer principle.
- (c) The cost is related to goods and/or services actually provided in the nursing facility.

4.3 Non-Recurring Costs

(a) Non-recurring costs shall include:

- (1) any reasonable and resident-related per diem cost that exceeds one percent of the most recent certified overall per diem rate, which is not expected to recur on an annual basis in the ordinary operation of the facility, may be designated by the Division as a "Non-Recurring Cost" subject to any limits on the cost category into which the type of cost would otherwise be assigned.
- (2) litigation expenses recognized pursuant to subsection 4.20.

(b) A non-recurring cost shall be capitalized and amortized and carried as an on-going adjustment beginning with the first quarterly rate change after the settlement of the cost report for a period of three years.

4.4 Interest Expense

(a) Necessary and proper interest is an allowable cost.

(b) "Necessary" requires that:

(1) The interest be incurred on a loan made to satisfy a financial need of the provider.

(2) A financial need does not exist if the provider has cash and/or cash equivalents of more than 75 days cash needs.

(3) Cash and cash equivalents include:

(i) monetary investments, including unrestricted grants and gifts,

(ii) non-monetary investments not related to resident care that can readily be converted to cash net of any related liability,

(iii) receivables from (net of any payables to) officers, owners, partners, parent organizations, brother/sister organizations, or other related parties, excluding education loans to employees.

(iv) receivables that result from transactions not related to resident care.

(4) Cash and cash equivalents exclude:

(i) funded depreciation recognized by the Division,

(ii) restricted grants and gifts.

(5) Interest expense shall be reduced by realized investment income, except where such income is from:

(i) funded depreciation recognized by the Division pursuant to HCFA-15,

(ii) grants and gifts, whether restricted or unrestricted.

(6) The provider must have a legal obligation to pay the interest.

(c) "Proper" requires that:

(1) Interest be incurred at a rate not in excess of what a prudent buyer would have had to pay in the money market existing at the time the loan was made.

(2) Interest must be paid to a lender that is not a related party of the borrowing organization except as provided in paragraph (k).

(d) Interest expense shall be included in property costs if the interest is necessary and proper and if it is incurred as a result of financing the acquisition of fixed assets related to resident care.

(e) The date of such financing must be within 60 days of the date the asset is put in use, except for assets approved through the Certificate of Need process or approved by the Division under Subsection 4.11 of this rule. Allowable interest, on loans financed more than 60 days before or after the asset is put in use, will be included in Indirect Costs for the entire term of the loan.

(f) Borrowings to finance asset additions cannot exceed the sum of the basis of the asset(s), determined in accordance with Subsections 4.5 and 4.7, and the bank finance charges related to the borrowing. The limit on borrowings related to fixed assets is determined as follows:

Basis of the assets recognized by the Division

Plus: Bank finance charges

Less: The provider's cash down payment and cash and cash equivalents in excess of 75 days needs, per subparagraph (b)(2) of this subsection.

Equals: The limits on borrowings related to fixed assets.

(g) Other costs may be included in loans where the interest is recognized by the Division. These costs include points and costs for legal and accounting fees, and discounts on debentures and letters of credit.

(h) Necessary and proper interest expense not applicable to property related debt shall be recognized as working capital interest expense and included in Indirect Costs.

(i) If interest expense related to a specific financing arrangement is related to asset acquisitions and working capital, principal payments shall be applied first to loan balances related to asset acquisitions and the working capital loan and second to non-recognized loan balances.

(j) Refinancing of indebtedness.

(1) The provider must demonstrate to the Division that the costs of refinancing will be less than the costs of the current financing.

(2) Costs of refinancing must include accounting fees, legal fees and debt acquisition costs related to the refinancing.

(3) Material interest expense related to the original loan's unpaid interest charges, to the extent that it is included in the refinanced loan's principal, shall not be allowed.

(4) A principal balance in excess of the sum of the principal balance of the previous financing plus accounting fees, legal fees and debt acquisition costs shall be considered a working capital loan, subject to the cash needs test in subsection 4.4(b)(2), unless the provider demonstrates to the Division that the excess was for the acquisition of assets as set forth in (a) through (g).

(k) Interest expense incurred as a result of transactions with a related party (or related parties) will be recognized if the expense would otherwise be allowable and if the following conditions are met:

(1) The interest expense relates to a first and/or second mortgage or to assets leased from a related party where the costs to the related party are recognized in lieu of rent.

(2) The interest rate is no higher than the rate charged by lending institutions at the inception of the loan.

(1) Interest is not allowable with respect to any capital expenditure in property, plant and equipment related to resident care which requires approval, if the necessary approval has not been granted.

4.5 Basis of Property, Plant and Equipment

(a) The basis of a donated asset is the fair market value.

(b) The basis of other assets that are owned by a provider and used in providing resident care shall generally be the lower of cost or fair market value. Specific exceptions are addressed elsewhere in this rule. Cost includes:

(1) purchase price,

(2) sales tax,

(3) costs to prepare the asset for its intended use, such as, but not limited to, costs of shipping, handling, installation, architectural fees, consulting and legal fees.

(c) The basis of assets constructed by the provider to provide resident care shall be determined from the construction costs which include:

(1) all direct costs, including, but not limited to, salaries and wages, the related payroll taxes and fringe benefits, purchase price of materials, sales tax, costs of shipping, handling and installation, costs for permits, architectural fees, consulting fees and legal fees.

(2) indirect costs related to the construction of the asset.

(3) interest costs related to capital indebtedness used to finance the construction of the asset and prepare it for its intended use.

(d) The basis of betterments or improvements, if they extend the useful life of an asset two or more years or significantly increase the

productivity of an asset are costs as set forth in paragraphs (b) and (c) above.

(e) Any asset or group of assets that has a basis of \$500 or more and an estimated useful life of two or more years must be capitalized and depreciated in accordance with Subsection 4.6.

(f) The gain on a transfer of an asset to a related party shall be calculated as follows: the fair market value of the asset, less the net book value will be the gain irrespective of the amount paid to the facility for the asset. This gain will be offset against property and related costs.

4.6 Depreciation and Amortization of Property, Plant and Equipment

(a) Costs for depreciation and amortization must be based on property records sufficient in detail to identify specific assets.

(b) Depreciation and amortization must be computed on the straight-line method.

(c) The depreciable basis of an asset shall be the basis established according to Subsections 4.5 and 4.7, net of any salvage value.

(d) The estimated useful life of an asset shall be determined by the Division as follows:

(1) The recommended useful life is the number of years listed in the most recent edition of *Estimated Useful Lives of Depreciable Hospital Assets*, published by the American Hospital Association.

(2) Leasehold improvements may be amortized over the term of an arms-length lease, including renewal period, if such a lease term is shorter than the estimated useful life of the asset.

4.7 Change in Ownership of Depreciable Assets - Sales of Facilities

(a) A change of ownership will be recognized when the following criteria have been met:

(1) The change of ownership did not occur between related parties, except for transac-

tions that meet the criteria in subparagraph (2).

(2) The transaction takes place between family members and meets the following conditions:

(i) The Division shall be notified at least two years before the sale. The notice shall include a description of the terms and conditions of the sale and be accompanied by a current appraisal of the facility being sold.

(ii) The buyer shall demonstrate the capacity to manage and/or administer the facility; or if the buyer is to be an absentee owner, the buyer shall demonstrate that there will be sufficient capable staff to operate the facility according to standards prescribed by state and federal law.

(iii) The seller shall not maintain full time employment with the facility, except for a transition period which shall not be longer than one year during which the seller may provide reasonable consultation to assure a smooth transition.

(iv) A sale of the facility shall not have occurred between any members of the same family within the previous 12 years.

(v) For the purposes of this subsection, family members shall include spouses, parents, grandparents, children, grandchildren, brothers, sisters, spouses of parents, grandparents, children, grandchildren, brothers and sisters, aunts, uncles, nieces and nephews, or such other familial relationships as the Director may reasonably approve in the circumstances of the transaction.

(3) The change of ownership was made for reasonable consideration.

(4) The change of ownership was a bona fide transfer of all the powers and indicia of ownership.

(5) The change in ownership is in substance the sale of the assets or stock of the facility and not a method of financing.

(i) If the transferor and the transferee enter into a financing agreement, the agreement must be constructed to effect a complete change of ownership. The Division shall determine if the agreement does in substance effect a complete change of ownership and the Division shall monitor the compliance with the agreement.

(ii) Where, subsequent to a change of ownership, the transferor forgives or reduces the debt of the transferee, the amount of the forgiveness or reduction shall be retroactively applied to the acquisition or basis of the asset as determined by the Division.

(6) The buyer shall demonstrate to the satisfaction of the Division that all obligations to the State of Vermont arising out of the transaction have been satisfied.

(7) For rate setting purposes, the transfer of stock or shares shall not be recognized as a change in ownership in the following circumstances:

(i) the transferred stock or shares are those of a publicly traded corporation.

(ii) the transfer was made solely as a method of financing (not as a method of transferring management or control) and the number of shares transferred does not exceed 25 percent of the total number of shares in any one class of stock.

(b) Where the Division recognizes the change in ownership of an asset, the basis of the assets for the new owner shall be determined as follows:

(1) If the seller did not own the assets during the entire twelve year period immediately preceding the change in ownership or if the seller's facility did not receive Vermont Medicaid reimbursement during the entire